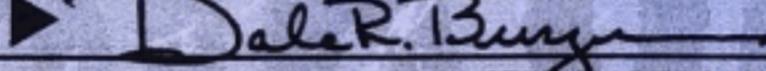
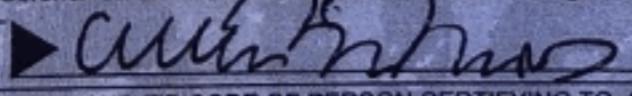


3

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION OFFICE
PHYSICIAN'S / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
350 CAPITOL STREET, ROOM 165, CHARLESTON, WV 25301

FILED
09/03/2018
STATE FILE NUMBER

FUNERAL DIRECTOR NAME OF DECEASED BULGER, James J.		1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last)				2. SEX	3. SOCIAL SECURITY NUMBER		
		James Joseph Bulger Jr.				Male			
		4a. AGE (Last Birthday) (Years)	89	4b. IF UNDER 1 YEAR	4c. IF UNDER 1 DAY	5. DATE OF BIRTH (MM/DD/YYYY)	6. BIRTHPLACE (City and State or Foreign Country)		
				Months	Days	Hours	Minutes	09/03/1929	Boston, MA
		7a. RESIDENCE (STATE)		7b. COUNTY		7c. CITY OR TOWN			
		MA		Suffolk		Boston			
		7d. STREET AND NUMBER 17 Twomey Court				7e. APT. NO.	7f. ZIP CODE	7g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		7h. 2nd LEGAL RESIDENCE - PROBATE USE ONLY - OPT.		STREET & NUMBER		APT. NO.	CITY OR TOWN	COUNTY	STATE ZIP
		8. EVER IN US ARMED FORCES?		9. MARITAL STATUS AT TIME OF DEATH <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Unknown			10. SURVIVING SPOUSE'S NAME (Give name prior to first marriage.)		
		11. FATHER'S / PARENT 1'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)				12. MOTHER'S / PARENT 2'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)			
James Joseph Bulger Sr.				Jane V. McCarty					
13a. INFORMANT'S NAME		13b. RELATIONSHIP TO DECEDENT		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)					
14. PLACE OF DEATH (Check only one: see instructions)									
IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival				IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify): Prison					
15. FACILITY NAME (If not institution, give street & number)		16. CITY OR TOWN, STATE, AND ZIP CODE			17. COUNTY OF DEATH				
U.S. Penitentiary Hazelton		Bruceton Mills, WV 26525			Preston				
18. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify):		19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place - location in Box 20.) Saint Josephs Cemetery							
20. DISPOSITION LOCATION (City, State)		21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY Charleston Mortuary Service 1101 Bigley Avenue Charleston, WV 25302							
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH  Dale R. Burger									
23. LICENSE NUMBER (Of Licensee)									
24. DATE PRONOUNCED DEAD (MM/DD/YYYY)		25. TIME PRONOUNCED DEAD							
10/30/2018		0904							
26. SIGNATURE AND TITLE OF PERSON PRONOUNCING DEATH (Only when pronouncer IS NOT also the certifier.) 									
27. DATE SIGNED (MM/DD/YYYY)									
28. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) <u>Found 10/30/2018</u>		29. ACTUAL OR PRESUMED TIME OF DEATH <u>found 0821</u>		30. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		IF YES, MEDICAL EXAMINER CASE # <u>18-6303</u>			
CAUSE OF DEATH									
31. PART I. Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. Enter only one cause on a line. Add additional lines if necessary.									
IMMEDIATE CAUSE → a. <u>Blunt Force Injuries of the Head</u> Due to (or as a consequence of):									
Approximate Interval Between Onset and Death <u>minutes</u>									
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST		b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause in PART I.				32a. WAS AN AUTOPSY <input checked="" type="checkbox"/> Yes PERFORMED? <input type="checkbox"/> No		32b. WERE AUTOPSY FINDINGS <input checked="" type="checkbox"/> Yes AVAILABLE TO COMPLETE THE <input type="checkbox"/> No CAUSE OF DEATH?			
33. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		34. IF FEMALE <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the last year		35a. CAUSE/MANNER PENDING? <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Date Amended See 35b. for Final Manner of Death		35b. FINAL MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
36a. DATE OF INJURY <u>found 10/30/18</u>		36b. TIME OF INJURY <u>found 0821</u>		36c. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, office building, wooded area) <u>Prison Cell - U.S.P. Hazelton</u>					
36d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
36e. LOCATION OF INJURY: <u>1640 Skyline Drive; Bruceton Mills, WV 26525</u>		Street & Number:		Apt No.:	City or Town:	State or Country:	Zip Code:		
36f. DESCRIBE HOW INJURY OCCURRED <u>Assaulted by other(s)</u>				36g. IF TRANSPORTATION INJURY: ROLE: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify):					
SEATBELT RESTRAINT STATUS: <input type="checkbox"/> Restrained <input type="checkbox"/> No restraint <input type="checkbox"/> Unknown HELMET STATUS: <input type="checkbox"/> Helmet <input type="checkbox"/> No helmet <input type="checkbox"/> Unknown									
37a. CERTIFIER (Check only one): <input type="checkbox"/> Certifying Physician or Qualified APRN -To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Pronouncing & Certifying Physician or Qualified APRN -To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner/Coroner-On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.									
Signature of Certifier 		Date Certified <u>10/31/18</u>							
37b. PRINT NAME, ADDRESS, AND ZIP CODE OF PERSON CERTIFYING TO CAUSE OF DEATH (Item 31) Allen Mock, CME, OCME Main				37c. TITLE OF CERTIFIER		MD			
38. FOR OFFICIAL REGISTRAR USE ONLY- SIGNATURE OF REGISTRAR 				39. FOR OFFICIAL REGISTRAR USE ONLY- DATE FILED <u>11/14/2018</u>					